

AMERICAN MEDICAL TIMES

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H A N D - B O O K

OF

S U R G I C A L O P E R A T I O N S.

BY*

STEPHEN SMITH, M.D.,

SURGEON TO BELLEVUE HOSPITAL.

From the "Buffalo Medical and Surgical Journal and Reporter," July, 1862.

The book is rendered convenient and portable, and may be carried as a reference and guide in all emergencies. Almost every important operation is represented by engravings which illustrate the subject to the fullest extent practicable, and add very much to the value of the work. Illustrations of instruments are also made, which represent the latest improvements, and constitute also an important addition. Though this hand-book of surgery is made to conform to the necessities of military surgery, still it is also a valuable hand-book of surgery in civil practice as well; and almost every operation in surgery is described with sufficient detail for the ordinary purposes of study and practice. As a hand-book of surgery, it stands at the head of a long list of similar books.

Letter from one of the Surgeons of the University Hospital, Nashville, Tenn.

UNIVERSITY HOSPITAL.
Nashville, Tenn., June 26th, 1862.

Your "Hand-Book of Surgical Operations" has reached Nashville. It is a beautiful thing, and perfect as far as it goes. The plates admirably illustrate the text. It is complete as a military hand-book of operative surgery, and is very highly spoken of by all the surgeons who have examined it.

From the "Boston Medical and Surgical Journal," June 19th, 1862.

This treatise was prepared, as the author says in his preface, at the suggestion of a number of professional friends who had been called from their usual avocations to act as regimental surgeons in the United States Army. They have felt the want of a manual of operative surgery at once portable, exact, up to the present stage of surgical knowledge, and fully and clearly

illustrated. It is very evident that many of our professional brethren on whom the grave responsibilities of a military surgeon have fallen, could not be expected to represent in their own attainments at the moment, all that such a work should contain. Neither could they carry about with them a cumbersome surgical library. What was wanted was something to refresh their memories, in as small a compass as possible. Such a work Dr. Smith may fairly congratulate himself on having made. Its scope is limited to those branches of operative surgery which are of the most importance to the military surgeon, and yet, with the exception of gun-shot wounds, the subjects treated are liable to engage the attention of the surgeon at any time. The work is most copiously illustrated by excellent and intelligible wood-cuts, taken from the highest authorities, and the print is remarkably clear and legible—no small recommendation when we think of the dubious light of the tallow dips, by which it must often be consulted by those for whose special benefit it is intended. Its flexible cover makes it handy for use, and packable in any space large enough to crowd it into. We gladly recommend it as a most valuable companion to surgeons in the field.

Letter from Prof. FRANK H. HAMILTON, *Med. Director of the 4th Corps d'Armée, Army of the Potomac.*

HEADQUARTERS, GEN. KEYES' CORPS,
Near Harrison's Landing, Va., July 22, 1862.

I have had the pleasure of looking over the "Hand-Book of Surgical Operations" by Stephen Smith of New York, and do not hesitate to pronounce it the best book yet published for the use of army surgeons; and as such I have recommended it to all the army surgeons I have met.

FRANK H. HAMILTON,
Med. Director 4th Corps.

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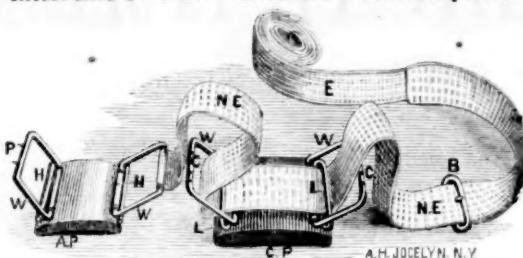
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Original Lectures.

LECTURES

ON THE

DIAGNOSIS OF DISEASES OF THE HEART.

DELIVERED AT THE

BELLEVUE HOSPITAL MEDICAL COLLEGE DURING THE
PRELIMINARY TERM.

SESSION 1862-63.

By AUSTIN FLINT, M.D.

PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE VII.—PART II.

Diagnosis of Inflammatory Affections of the Heart.—Physical Signs in Pericarditis.—Pericardial Friction-Sound or Exocardial Murmur.—Characters by which it is Discriminated from Endocardial Murmurs.—Symptoms in Pericarditis.—Mode of Ascertaining Distension of the Pericardial Sac by Physical Signs, and Discriminating it from Enlargement of the Heart.—Modification of the Heart-Sounds by Pericardial Effusion.—Diagnosis of Chronic Pericarditis, with Large Effusion.—Cardiac Pleural Friction-Sound.

I COME lastly, gentlemen, to consider the diagnosis of the inflammatory affections of the heart. The investing serous membrane, the pericardium, is liable to inflammation, constituting *pericarditis*; and the lining membrane of the cavities, the endocardium, is still oftener inflamed, constituting *endocarditis*. Inflammation of the muscular walls, *carditis*, is so exceedingly rare, that it would be of very little practical consequence to consider it, more especially since the diagnosis is impossible. I shall ask your attention, then, to the means of determining the existence of pericarditis and endocarditis, considering, first, the former of these affections.

The diagnosis of pericarditis rests almost exclusively on physical signs. These have been established since the time of Laennec. Laennec declared that the existence of this disease might be conjectured, but not positively determined. The researches of those who have followed in his footsteps have led to the knowledge of signs by means of which the diagnosis may be made with positiveness, certainly in the great majority of cases. Before we are prepared to understand the diagnostic signs of pericarditis, we must have a clear apprehension of the physical conditions which these signs represent. What is the physical condition in the first stage of this disease?

The pericardium is a serous membrane, and the appreciable effects of inflammation here are essentially the same as when other serous membranes are inflamed. We have, as an immediate or speedy effect, the exudation of liquor sanguinis, with coagulation of fibrin, constituting coagulable lymph, and the accumulation of serum in the pericardial sac. Before the serum has accumulated sufficiently to distend the sac, coagulable lymph is more or less diffused over the free surfaces of the membrane. The first stage may be reckoned from the development of inflammation, to the accumulation of liquid sufficiently to be made apparent by physical signs. The physical condition, then, in the first stage, which furnishes a diagnostic sign, is the presence of newly exuded lymph on the free surfaces of the membrane. This gives rise to the sign, obtained by auscultation, generally called the cardiac or pericardial friction sound; called, also, the attrition sound, or the to-and-fro sound, and, as distinguished from the murmurs produced within the heart (endocardial), it is called the *exocardial murmur*.

On the table before me are several specimens illustrating the morbid appearances due to recently exuded lymph. You will perceive, by examining the specimens, the diversity of appearances caused by the different modes in which the lymph is disposed on the pericardial surfaces; in some producing a shaggy appearance, in others giving rise to a

reticulated or honey-combed arrangement, and in others forming ridges. Here is a specimen which was obtained just before the commencement of my course. The pericardial sac, in this case, contained a large amount of liquid, and the whole surface of the heart was covered with lymph, leaving irregular depressions and ridges.

The rationale of the friction sound is sufficiently intelligible. We have seen that, during the systole of the heart, the apex moves from left to right, the organ elongates and rotates from left to right; these movements, of course, are reversed during the diastole. The systolic and diastolic movements involve the rubbing together, with more or less force, of the visceral and parietal surfaces of the pericardium. In health the rubbing together of these surfaces occasions no sound, owing to the smoothness of the membrane, which is polished and moist to facilitate freedom of motion. But when roughened by the presence of lymph, the friction is attended by sound—the friction sound—which varies in intensity and quality, according to the amount of lymph, its disposition, its diversity, the quantity of liquid effusion, and the force of the heart's action. A friction-sound almost invariably attends the first stage of pericarditis. In this respect pericarditis differs from pleuritis, the pleural friction-sound in the first stage of the latter affection being much oftener wanting. So uniformly is the pericardial friction-sound present in the first stage of pericarditis, that we may decide with much positiveness on the absence of the disease if this sign be absent.

What are the characters by which the pericardial friction-sound is distinguished? It is to be discriminated from the endocardial murmurs, and generally this discrimination is made without difficulty; but in some cases there is a liability to error without attention to the distinctive characters which I will proceed to mention.

A pericardial friction-sound is almost always double; that is, there are two sounds for each beat of the heart, one produced by the systolic, and the other by the diastolic movements. The systolic is the louder of the two sounds. This point is by no means distinctive, for, in certain cases of aortic lesions, we have a systolic and diastolic murmur. The liability of confounding exocardial and endocardial murmurs is chiefly in mistaking the aortic direct and aortic regurgitant murmurs for friction sounds, or *vice versa*.

The quality of friction-sounds generally denotes friction, or the rubbing together of surfaces which are not smooth. This quality differs in different cases. The sounds sometimes denote only slight grazing; in other cases they are more distinctly rubbing; in other cases they are rough, and may be described as rasping or grating sounds. These characters are somewhat distinctive, but it would not be safe to rely upon them exclusively. For the endocardial murmurs sometimes closely resemble friction-sounds in quality.

A point of much importance in this discrimination is the apparent superficial situation of friction-sounds. They seem to be very near the ear, and even to come from the surface, so that sometimes the auscultator looks to see if they may not be produced by the dress of the patient coming into contact with the stethoscope. Endocardial murmurs appear to have a deeper source, or to come from a greater distance.

Another point pertains to the situation in which they are heard. Friction-sounds are usually not propagated beyond the praecordia; frequently they are limited to the superficial cardiac space, and sometimes to the upper part of this space. On the contrary, endocardial murmurs are generally loudest beyond the borders of the heart, and are often propagated to a considerable distance from the praecordia. The aortic direct murmur is heard best above the heart, and extends upwards towards the summit of the chest, and the mitral regurgitant murmur is best heard without the apex, and is diffused to a greater or less extent around the chest. Limitation to the praecordia, or to a portion of this region, then, is one of the differential points involved in the discrimination.

Another point is the intensification of the sounds by pressure with the stethoscope. This is generally marked. In proportion as the pressure with the stethoscope is strong, the sounds are intensified. This is not true to the same extent of the endocardial murmurs; these are rendered louder by pressure only so far as the pressure promotes conduction, while the exocardial murmur becomes actually more intense.

Lastly, differential points relate to the fluctuations of friction-sounds and their relations to the normal sounds of the heart. Friction-sounds are apt to vary with different beats of the heart, being sometimes feeble, sometimes loud, and occasionally wanting. Endocardial murmurs are more constant and uniform, varying but little with the successive beats of the heart. Each of the endocardial murmurs, as we have seen, has a definite relation as regards the time of its occurrence, to either the first or the second sound of the heart, and this relation is preserved without variation. But friction-sounds have not the same fixed relations to the sounds of the heart. They are liable to occur, so to speak, discordantly as regards the heart-sounds, that is, not having the same precise and uniform connexions with these sounds as the endocardial murmurs.

Having determined the existence of a pericardial friction-sound, in conjunction with symptoms which denote the occurrence of inflammation within the chest, the diagnosis of pericarditis is made out. The symptoms are not distinctive of this inflammation. If the inflammation be acute, the patient has sharp, lancinating pain, referable to the precordia, aggravated by the acts of breathing, and resembling the pain of acute pleurisy. Painful, suppressed cough, such as exists in acute pleurisy, may be present. There is more or less febrile movement. The symptoms, in short, so closely resemble those of pleurisy, that the latter affection is supposed to exist by those who do not avail themselves of physical exploration. The two diseases, pleurisy and pericarditis, in fact, are not unfrequently combined, and the latter affection is then sure to be overlooked if only the symptoms are considered. In exploring the chest in cases of pneumonia, we are to bear in mind that pericarditis is not very unfrequently a complication of that disease, and we are to satisfy ourselves as regards the presence or absence of the pericardial friction-sound.

I pass now to consider the diagnosis of pericarditis in the second stage of the disease. The second stage dates from the accumulation of liquid effusion in sufficient quantity to be appreciable by means of physical signs, and this stage continues until marked progress has been made in the absorption of the effused liquid. From the latter period to the period of convalescence, we may reckon as the third stage, or stage of absorption; the middle stage we may call the stage of effusion.

The friction-sound may continue during the second stage, notwithstanding the accumulation of a large amount of liquid. This was illustrated in the case recently under observation, which furnished one of the morbid specimens before me. It was estimated that the pericardial sac, in that case, contained from twenty to thirty ounces of liquid; yet a loud friction-sound persisted to the end of life. In some cases, however, a friction-sound which had existed in the first stage disappears in the second stage. In the latter stage, then, we may or may not have the presence of this sign to guide us in the diagnosis. The diagnosis may be made in this stage without the advantage of the friction-sound. The diagnostic signs are those which denote distension of the pericardial sac.

In illustrating certain anatomical points in my first lecture, I called your attention to the form of the sac inclosing the heart. When distended it becomes a pear-shaped body; the space which it occupies, represented on the chest, is triangular, the base being below and the apex above. You will recollect that I pointed out the fact of the attachment of the sac being, not to the heart at its base, but to the great vessels two or three inches above the base of the heart. Hence, when distended, the apex rises nearly

or quite to the sternal notch, while the base of the sac is not much below the normal situation of the apex of the heart. Now, during the stage of effusion in pericarditis the pericardial sac is generally distended with liquid, and the space which it occupies is readily determined by percussion. Dulness or flatness exists in the pericardial region, within a triangular space which corresponds to the space occupied by the distended pericardium. Take, for example, the recent case which furnished the specimen before me. The space occupied by the distended pericardium, in this case, was delineated on the chest. The apex of the triangle reached nearly to the sternal notch; the base was a horizontal line between the sixth and seventh ribs; the left border of the triangle fell a little without the left nipple, and the right border fell a short distance within the right nipple. The borders of the distended sac are easily determined by percussion, because the dulness is increased in degree amounting frequently to flatness. We may also determine the borders by means of auscultation, which shows extinction of vocal resonance within a triangular space corresponding to the distended sac.

Increased extent and degree of dulness exist, as we have seen, in enlargement of the heart. Are not enlargement of the heart and distension of the pericardial sac, then, liable to be confounded? We avoid this error by bearing in mind the difference in the situation of the increased dulness in the two cases. When the heart is enlarged the base of the organ rises but little higher than its normal situation at the third rib, but it extends downwards and to the left; the increased area of dulness is, of course, in the same direction. On the contrary, as just seen, when the pericardial sac is distended, it extends but little below its normal situation at the fifth intercostal space, but it extends upwards towards the sternal notch.

Let me illustrate the points just stated by diagnosis on the chest of a living healthy subject. Suppose this person to have the pericardial sac distended with liquid; the pyriform tumor would occupy a space which I now delineate with ink. Now suppose him to have enlargement of the heart with the apex beating in the seventh intercostal space an inch without the nipple; I delineate with ink the space occupied by the enlarged organ. I have thus produced two diagrams on the chest, and you see how they differ as regards their forms and relative situations.

Other signs, during the stage of effusion in pericarditis, relate to the apex beat. When the liquid has accumulated sufficiently to distend the sac, the apex-beat is apt to be suppressed. Prior to the accumulation of liquid the apex-beat is generally abnormally strong. Its suppression, therefore, becomes a sign of effusion. If not suppressed it is enfeebled, and its situation raised; if felt at all it is generally felt in the fourth intercostal space. It may sometimes be felt by inclining the body of the patient forward, when it is inappreciable if the body be in the recumbent or vertical position.

The heart-sounds are modified by the presence of a considerable quantity of liquid. Both sounds are enfeebled, and seem to come from a greater distance than in health. The first sound loses its element of impulsion, becoming short and valvular like the second sound, and less intense. These modifications are sufficiently intelligible.

The pericardial region may be enlarged so as to be distinctly prominent. The intercostal spaces may be pushed out to the level of the ribs. These appearances alone point strongly to pericarditis with effusion.

The diminution of liquid in the pericardial sac is readily ascertained by means of percussion. Sometimes it is absorbed with such rapidity that the area of dulness is notably diminished on successive days; in other cases, the progress of removal is more slow, and sometimes the quantity fluctuates, being now more and now less. As the liquid disappears, the apex-beat returns if it have been suppressed, and becomes more and more apparent. The friction-sound reappears if it have disappeared during the second stage, and becomes louder if it have persisted through that stage.

This sign continues until agglutination or adhesion of the pericardial surfaces has taken place. It may continue not only during the stage of absorption, but into convalescence.

The symptoms, during the stage of effusion, are not more distinctive than during the first stage. The pain diminishes or ceases. The patient suffers from a distressing sense of oppression due to the compression of the heart. He is liable to syncope from any exertion. I have known sudden death to follow the effort of getting out of bed. Dyspnoea exists to a greater or less extent. The pulse is small and feeble. The surface of the body may present venous congestion. But all these symptoms are found in other intra-thoracic affections; and I repeat, the diagnosis of this disease is based almost exclusively on physical signs.

A few words, in conclusion, respecting chronic pericarditis with effusion. Chronic inflammation of the pericardium, as of other serous membranes, either following the acute disease or subacute from the beginning, may lead to a large amount of effusion. The pericardial sac becomes, not merely distended, but dilated, and it has been found to contain a gallon of liquid. In proportion as the sac undergoes dilatation it loses its pyriform shape, and increases especially in width. The lateral borders of the dilated sac may extend nearly, or quite, to the *linea axillaris*, or the centre of the lateral surface of the chest on either side. Under these circumstances, physical exploration suffices to show that the accumulation of liquid is in the pericardial sac. Dulness or flatness extends anteriorly on both sides, to a greater or less extent from the sternum, and beyond the limits of the dulness or flatness, on both sides, pulmonary resonance is found, and also at the base of the chest behind on both sides. This excludes pleurisy with effusion. The apex-beat, as a rule, is suppressed. The sounds of the heart are feeble and distant, the first sound resembling the second in duration and quality, and weaker than the second sound; and, in some cases, even with a very large accumulation of liquid, the diagnosis is confirmed by a friction-sound.

With reference to the friction-sound, it is proper that I should mention a source of fallacy which is occasionally met with. In a case of pleurisy affecting the left side, without pericarditis, the movements of the heart sometimes cause a rubbing of the external surface of the fibrous sac inclosing the heart, against the adjacent pleura roughened with lymph, and a friction sound is in this way produced. It is a cardiac friction-sound, that is, it is produced by the movements of the heart; it may be double, corresponding with the rhythm of the heart's movements, and not suspended by holding the breath, as is a pleural friction-sound dependent on the respiratory movements. The friction-sound referred to, is a *cardiac pleural friction-sound*. I have met with this fallacious sign in a few instances. Its occurrence in some cases of pleurisy affecting the left side, should lead us to hesitate in resting the diagnosis of pericarditis, as a complication, exclusively on the presence of a friction-sound.

M. MAISONNEUVE informs the Academy of one of his cases operated on by the *diastatic method*. A woman in the Hôtel Dieu had an ankylosis, resulting from fracture of the neck of the thigh, and was thereby prevented from walking. The "hardi" surgeon broke the ankylosis, and cured the patient. The voluntary fracture made by his diastatic apparatus was performed, we are told, without producing splinterings, or any injury to the soft parts.—*Brit. Jour.*

M. CHARCOT relates a case of exophthalmic goitre, in which all the symptoms were most favorably modified or arrested by the puerperal state. It appears that the same results have been observed in three cases recorded, in which the women became *enceinte* while suffering under this affection.—*Brit. Jour.*

M. CHASSAGNAC has communicated to the Société de Chirurgie a case of false aneurism of the femoral artery cured by digital compression in seven hours.—*Brit. Med. Jour.*

Original Communications.

CAN PREGNANCY FOLLOW DEFLORATION IN RAPE, WHEN FORCE SIMPLY IS USED?

BY EDMUND S. F. ARNOLD, M.D.,

OF YONKERS, N. Y.

HAVING lately been called upon to give evidence in a case of bastardy, in which it was averred by the female that she was violated after making all the resistance in her power, that she had not fainted nor lost her senses, nor had any draught or drugs been administered, nor threats made, that intercourse was had a second time the same night, that she had never had sexual intercourse with any one before or since, that she had been delivered of a child nine months after, and consequently that the ravisher was the father of the child: I testified, firstly, knowing both parties, that I did not consider it possible that the man could have accomplished the act, if she had resisted as long and as powerfully as she was able; and secondly, on being asked whether it were possible that pregnancy could follow rape, answered that it was perhaps possible, but very improbable. To controvert this last opinion East was quoted, who says: "It was formerly supposed that if a woman conceived it was no rape, because that showed her consent; but it is now admitted on all hands, that such an opinion has no sort of foundation either in reason or law." Taylor also says: "Such a question requires no discussion in the present day. Conception, it is well known, does not depend on the consciousness or volition of a female. If the state of the uterine organs be in a condition favorable to impregnation, this may take place as readily as if the intercourse was voluntary."

What I want to attempt to show in this article is, that in truly forcible violation, as alleged above, the uterine organs cannot well be in a condition favorable to impregnation. I may here state, once for all, that my arguments apply to such cases only. Maybe they are not new, but I do not find anything bearing on this class of cases in Beck or Taylor, otherwise than that in the former work it says of Bartley's opinion on the subject: "The scope of his argument is, that the depressing passions, such as fear, terror, etc., will prevent the necessary orgasm from occurring. That is also the ground I shall take."

It is asserted in proof of pregnancy following rape, that females have conceived while under the influence of narcotics, of intoxication, and even of asphyxia—admitted. It is asserted also that the functions of the uterine system are in a great degree independent of the will, and I admit that also, the uterus being mainly dependent on the organic nervous system, not on the voluntary. We find the uterus as little affected by any of the above influences during the whole after period of gestation.* A woman may be intoxicated frequently, may be almost poisoned with narcotics without disturbing gestation, unless it be by poisoning the source of nourishment of the fetus and so destroying it; while by many the use of chloroform or other anesthetics, is believed to promote the healthy action of the uterus during parturition, by relieving pain and the removal of disturbing causes, while destroying the will and relaxing impeding muscles dependent immediately on the cerebro-spinal system. So little has sensation or volition to do with the matter, that Carpenter observes: "It is an interesting fact, which has been more than once observed, that the fetus may be expelled from the dying body of the mother even after the respiratory movements have ceased." Thus we see from first to last, that those agents which are not calculated to prevent conception, exert as little influence during the whole after period of gestation.

I can even believe that impregnation may follow defloration more readily when soporifics are administered than when not, just by the removal of those disturbing influences which

seem not only to render the uterus incapable of conceiving, but which we know positively to exert a most powerful influence on that organ during the subsequent period of pregnancy, viz. terror, distressing emotions, or whatever produces a severe shock to the general nervous system. Mark what the same East, already quoted, says: "It has been inquired whether pregnancy may follow defloration? I apprehend that this is to be answered in the affirmative, although the instances are comparatively rare." Comparatively rare where there is consent, for the evidences here are mainly to be sought in married life. We undoubtedly meet occasionally with a case where there is reason to suppose conception has resulted from defloration. Within a very short period, a patient in labor innocently remarked: "I did not think I could have been sick so soon, it was only nine months yesterday since I was married." But I think it will be found to be the general experience of medical men, that such cases are rather the exception than the rule. Besides, some are less affected by the influences under discussion than others, in some they may not be called into action at all, and in such cases a woman may be in as favorable a condition for impregnation as at any future time. Ten months after marriage, or later, are the more common periods at which women bear their first fully matured child; hence it would seem that a certain period is required in most cases to overcome some disturbing causes, which have a direct influence in preventing the conception, whatever they may be. In the domestic animals impregnation is as certain to occur at the first coitus as at a future time; why not then also in the human female, unless emotional influences, absent in the former, but prevailing in different degrees of intensity in the latter, disturb materially the organic nervous system, upon an underranged condition of which the uterus is dependent for the proper performance of its functions when specially called into action.

If conception is infrequent as a result of defloration in virtuous females where there is consent, how much more likely is it to be rare when a strong man overpowers a weak woman, where in the former the coarser and more brutal passions are brought into play, culminating in violence even more than necessary to accomplish the crime, while in the latter, repugnance, terror, pain, and bruising of parts, violent resistance succeeded by almost total prostration, all contribute to cause severe shock to the organic nervous system, so deranging it as to deprive, for the time, the uterus of that supply of healthy nervous influence necessary for the due performance of its functions, often so affecting the entire system as subsequently to lead to fevers, violent hysteria, or even eclampsia. I believe it to be as impossible for a woman to conceive while under the influence of terror, shock, and nervous exhaustion, as it would be for a man to perform the act of intercourse while prostrated by similar agencies.

As might be supposed, the same influences affect powerfully the uterus during the whole after period of gestation. What is more likely to produce miscarriage than a fright, or any sudden shock to the nervous system? Is it then reasonable to suppose, that while terror, or strong and painful emotions, especially those of a sudden character, will affect the uterus so powerfully as to cause it to lose its contents, that it can be independent of them during coitus; that it shall, in fact, be independent of them at one moment only to become peculiarly sensitive to them from that time forward?

While then the uterus is admitted to be sufficiently independent of the mere will, it certainly cannot be proved that conception may occur during a first and forcible coitus, by citing cases to show that it may follow the exhibition of narcotics or sedatives; on the contrary, to reach such a case as I have started with at the commencement of this article, we have to show that it may occur under circumstances of an entirely opposite character, viz. those of intense and overwhelming excitement of a painful kind. I can believe that a woman of virtuous impulses may be so overcome by passion excited in resisting a sudden assault, that a

vigorous opposition may subside into passive submission, and that impregnation may result, but then she becomes a consenting party in the eye of the law. It is not a rape. I can also readily conceive that, impelled by shame, she may stoutly assert that she had resisted to the extent of her power, and her antecedents and subsequent conduct may lend undue weight to her statements in the absence of positive proof, which it is impossible to obtain. The older writers, then, may not be so far wrong after all, when they assert that pregnancy shows consent (at least where no other means than actual exertion of strength to accomplish the act are used), that is, such consent as would reduce the crime from that of rape in law to a mere assault.

YONKERS, N. Y., Nov. 11, 1862.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

BY AUSTIN FLINT, M.D.,

PROF. OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

MR. PRESIDENT—After the extended, comprehensive, and instructive discourses recently delivered in this place,* I could hardly have consented to address the Academy, save with the understanding that my function is simply to open a discussion of the subject. With this understanding I shall not trespass long on the patience of the fellows who are present, and shall aim only to present some of the more important of the practical questions relating to the pathology and causation of albuminuria, giving, as concisely as possible, the views relating thereto, which appear to my mind most consistent with our present knowledge. As regards the discourses referred to, let me express congratulations that Prof. Clark has been induced to bring before the Academy his elaborate researches, especially on the morbid anatomy of the kidney, and that they are now placed before the profession in a form available, not only by the present generation, but by those who are to come after us.

The first question which suggests itself, has reference to the scope of the term albuminuria; what is meant by this term? When Dr. Bright published his discovery in 1827, and for some time afterwards, it was supposed that albumen in the urine always denotes disease of the kidneys. It is now well known that albumen in the urine occurs incidentally in a host of affections. Albumen is found in the urine occasionally in all the essential fevers, in scrofula, in pneumonia, in diabetes, etc., etc. It is a symptom like cephalgia, for example, which, although a prominent feature of acute meningitis, is yet common to numerous diseases. As a rule, when albuminuria occurs, thus, as an incidental symptom, or accident, the quantity is small and it is of transient duration. On the other hand, it is by no means always abundant, and it is not always present in connexion with those morbid conditions of the kidneys which, for lack of a more distinctive name and as a proper tribute to the discoverer, are embraced under the title of Bright's disease. In the present discussion, the term albuminuria is used as expressing an affection or affections of the kidneys, not merely a symptom occurring in other pathological connexions. It is to be limited to cases in which, from the quantity or continuance of albumen in the urine, and other associated events, certain morbid conditions of the kidneys are represented, and also it is applied to cases in which these conditions exist, although albumen may not be contained in the urine.

The next question which arises is—What are the morbid conditions of the kidneys usually represented by albuminuria, or comprehended by the name of Bright's disease?

The morbid appearances, gross and microscopical, have been very fully considered by the distinguished fellow who has preceded me, and who, as is well known, has devoted to them special research. It would not only be superfluous but presuming in me to undertake to go into this branch of the subject, more especially as regards the microscopical ap-

* By Prof. Alonzo Clark.

pearances, inasmuch as I cannot claim to have been a worker with the microscope to much extent. To the student of medicine and medical reader, the morbid anatomy of Bright's disease is apt to present considerable complexity, not to say confusion, owing to the discrepancy in the views of different observers as regards the various forms of the disease. Bright himself describes three forms; Christison recognised the same number; Martin Solon, of Paris, has described five varieties; Rayer six, and Rokitansky has extended the number to eight. These divisions are based mainly on differences in the gross appearances. More recently Dr. George Johnson, of London, basing his divisions in a great measure, on microscopical appearances, considers that there exist five different forms. In a practical point of view, however, the important inquiry is—What are the *immediate pathological effects* of the conditions giving rise to such a diversity of appearances? Directing attention to this inquiry, there is far less complexity than in considering the morbid conditions in a purely anatomical point of view. It seems to me that the immediate pathological effects of these conditions are resolvable into two classes, viz. *First*, interference with the secretory function of the kidneys, especially as regards the elimination of urea. *Second*, interference with the circulation in the kidneys. Let us consider, briefly, how these two classes of immediate effects are produced.

How is the secretory function interfered with? In two modes. One mode is the obstruction or plugging of the convoluted tubes. The presence of fibrinous moulds in the tubes, the accumulation of epithelium, of granular matter, of fat, of that unknown deposit called lardaceous or amyaceous, may interfere with secretion simply by producing pressure on the secreting cells, these remaining intact. The operation is mechanical. Another mode is the disintegration and destruction, to a greater or less extent, of the secreting tissue. In certain cases the epithelium of the tubes is injured or lost, the tubes sometimes being completely denuded of their epithelial lining.

How is the circulation of the kidney interfered with? Here, also, in two modes. One mode is, the pressure of morbid products on the intertubular veins, sometimes called the portal veins of the kidney, the morbid products being fibrin, epithelium, granules, and other deposits either within the tubes, in the intertubular spaces, or in both situations; and as a consequence of this pressure, congestion of these veins, and especially of the Malpighian tufts. The other mode involves the dependence of the circulation on the functional activity of the kidneys. If the secretion be diminished, congestion is induced in accordance with a general law, viz. that whenever in any organ the function of that organ is interfered with, the interference extends to the circulation. Take, for example, the lungs; if, from any cause, apnoea be produced, these organs become congested. Much importance is attached by Johnson and others to congestion produced in this way by pathological conditions of the kidneys interfering with their secretory function.

We may here trace the consequences of the morbid conditions of the kidneys a step further onward. The immediate pathological effects just considered give rise to two classes of ulterior effects. *First*, uræmia. This ulterior effect is attributable to the non-secretion of urea. The urea, being preformed in the blood, if not eliminated by the kidneys, or vicariously by some other organ, is of course retained in the blood, and accumulating, gives rise to the morbid condition known as uræmia. *Second*, the presence of albumen in the urine. This ulterior effect is attributable to interference with the circulation in the kidneys. Instead of the transudation of water holding in solution the saline constituents of the urine, the serum of the blood transudes holding in solution albumen; hence, albuminuria. And perhaps in this situation, owing to the thin walls of the vessels composing the malpighian tufts, an exudation of fibrin or lymph may take place into the convoluted tubes, as a result of congestion merely, furnishing an exception to the rule that this exudation is a criterion of inflammation.

I come now to another question: Are the different morbid conditions of the kidneys different phases, modifications, or stages of one affection of these organs, or are they intrinsically different affections?

Bright appears not to have entertained a decided opinion on this point, although he inclined to regard the different forms as pathologically identical. Christison considered the different forms as successive steps of one affection. More recently this view has been advocated by Reinhardt and Frerichs. Prof. Clark regards the diversities in the morbid anatomy as proceeding from different modifications of one affection, together with incidental or accidental changes arising from the state of the blood or the condition of the system. Many, if not most, pathologists at the present time, hold to intrinsic and essential differences between certain of the different morbid conditions. I confess that this view appears to my mind most consistent with our present knowledge.

Take in the first place a division which all observers recognise, into the large kidney and the small or atrophied kidney. According to Christison and Frerichs, the small kidney represents simply a more advanced stage of disease than the large kidney; the kidney, when found to be atrophied after death, was, at a certain period prior to the fatal result, a large kidney; and the kidney found to be large after death would have eventuated in the small kidney, had the life of the patient been sufficiently prolonged. Of course, it is not contended that this change in these organs is demonstrable. We cannot trace deviations in the size of the kidneys, as we can of the liver during life. The point is to be settled by inferential reasoning. I will state, briefly, the grounds for the opinion which I have just expressed in opposition to the view of Christison, Frerichs, and others. The evidence to my mind that the large and the small kidney do not constitute different stages of one affection, is afforded by the fact that the previous clinical history, in cases of the small kidney, does not present the symptoms pertaining to the large kidney. As we shall presently see, and as is well known, the symptoms of the large and of the small kidney are, to a considerable extent, distinctive, so much so, that the differential diagnosis may generally be made. The immediate pathological effects in the kidney differ, in the small kidney the secretory function, and in the large kidney the circulation being especially interfered with. Now, we meet with cases of the following description: a patient is suddenly attacked with symptoms of uræmia. Prior to the attack there were no manifestations of any affection of the kidney. Perhaps the patient considered himself well. Death occurs suddenly, or in a short time, and after death the kidneys are found to be atrophied. In such cases it seems to me altogether improbable that the large kidney has existed without any of the symptoms which, as we shall presently see, belong to that condition. Again, we meet with cases in which albuminuria has existed for a long period—many months and even years; the patient at last dies, and the large kidney is found after death. Now, when the disease is thus prolonged, if the view entertained by Christison and Frerichs be correct, we ought to find the small kidney after death.

Take, in the second place, another division which is in like manner generally recognised, viz. into acute and chronic albuminuria. The acute and the chronic disease occur separately. Acute albuminuria, as a rule, does not end in the chronic; and the chronic, as a rule, is not preceded by the acute. But a much stronger point of difference is this: The morbid conditions in acute albuminuria may be, and often are, recovered from; the lesions are not necessarily destructive, while recovery from chronic albuminuria very rarely if ever takes place—the lesions are destructive and incurable. According to Johnson, in acute albuminuria the morbid conditions of the kidneys consist in the accumulation of desquamated epithelium and fibrin within the convoluted tubes. However this may be, clinical observation shows that the organs are not disorganized; and in this point of view, the difference between acute and

chronic albuminuria is not less than the difference between capillary bronchitis and pulmonary tuberculosis.

To recapitulate points of distinction already referred to: In the small kidney, we have disorganizing lesions; the secretion interfered with more than the circulation; the lesions consisting in the loss of epithelium, new products of disease being either wanting or not abundant. In the large kidney we have morbid products more or less abundant—fibrinous, albuminoid, fatty, together with, in certain cases, more or less destruction of the secreting tissue; the circulation frequently interfered with more than the secretory function; the products of disease remaining, and the organs disorganized. In the acute affection we have a condition or conditions of the kidneys not necessarily disorganizing or destructive, but admitting of complete recovery.

We are led now to a question which is, in fact, involved in that just considered. Is albuminuria to be considered as one disease, or does this term embrace several diseases? I have been led to think that the latter is the correct view; that is, the term embraces several different diseases. There seem to me to be sufficient grounds for recognizing at least three distinct diseases, viz. 1. Acute albuminuria; 2. Chronic albuminuria with enlargement of the kidney, or without contraction; 3. Chronic albuminuria with contraction or atrophy. The individuality of each of these diseases is shown by facts pertaining to the kidney, already noticed, together with facts pertaining to the clinical history. Let me here enumerate the facts showing the individuality of each of these diseases.

First, of Acute Albuminuria. Examples of this disease are afforded by cases occurring in the progress or as a sequel of scarlatina; but cases occur independently of any connexion with scarlatina. In this disease, the pathological conditions of the kidneys may be recovered from, and are recovered from in the majority of cases. Dropsy is usually marked. The urine is generally scanty, sometimes containing blood in an appreciable quantity (haematuria), and often containing haematin, giving to the urine a smoky or sooty appearance. The sediment of the urine in most cases abounds in casts, which are of the epithelial variety, and, also, of the waxy, or hyaline; and the latter are of small size, the diameter varying from $\frac{1}{16}$ to $\frac{1}{32}$ of an inch. The albumen in the urine is abundant. Cases may end fatally by uræmic poisoning, but this is an accidental result. It is aggravating to lose a patient by this accident, for, if it had not occurred, the case would probably have ended in recovery. I have the records of several cases of acute albuminuria ending in recovery, exclusive of cases occurring in connexion with scarlatina. In some of these cases the disease occurred many years ago—in one as far back as ten years—the patients remaining in good health.

Second, of Chronic Albuminuria, with the large, or not contracted, kidney. This disease is chronic, or subacute, from the commencement. It is developed insidiously. Generally dropsy is the first event manifested, and this, in general, becomes marked. The albumen in the urine is more or less abundant; very rarely wanting. The urinary sediment sometimes contains casts, and sometimes not. The casts, when present, are granular, containing disintegrated epithelium, and waxy of large and small size, or containing oil drops. The disease is fatal sooner or later; the apparent recoveries being only apparent, not real. It may prove fatal by uræmic poisoning; but often the fatal ending is by asthenia, no symptoms of uræmic poisoning having been manifested during the whole course of the disease. Nausea and vomiting are apt to be prominent symptoms. There is progressive loss of strength; anaemia is a prominent feature; and if uræmic poisoning do not occur, the patient dies exhausted after a protracted duration of the disease.

It remains to be ascertained by clinical observation, whether this form of Bright's disease may not be further subdivided; in other words, whether the different varieties of the large kidney are not characterized by differences, as

regards clinical history, sufficient to invest them respectively with a distinct individuality.

Third, of Chronic Albuminuria with contracted kidney. This, from the beginning, is a chronic or subacute disease. It is apt to be even more insidious in its development than chronic albuminuria with the large kidney. The dropsy is less, and is not infrequently very slight, or wanting. The albumen in the urine is slight, and may be absent. I believe absence of albumen not to be the rule in this disease, but that it is wanting in a certain proportion of cases. The disease generally proves fatal by uremia; rarely, if ever, by asthenia. Phenomena of uræmic poisoning may be the first obvious symptoms of the disease. It sometimes proves rapidly fatal by uremia, and cases occur in which sudden death takes place with uræmic coma, and the existence of disease of the kidneys had not been suspected. In some cases a fatal result occurs from local inflammations incidental to uremia, inflammations especially of the serous membranes—peritonitis, pleuritis, pericarditis. The sediment of the urine contains casts which are granular and waxy. The latter are of large size; they have been found to measure only $\frac{3}{16}$ of an inch in diameter.

As regards casts of the uriniferous or convoluted tubes found in the sediment of the urine, the researches of Dr. George Johnson, if they are confirmed by clinical observation, seem to me to be of great importance in their application to diagnosis. In the first place, they are of great diagnostic value in the cases in which (the solecism is admissible in accordance with our definition) albuminuria exists without the presence of albumen in the urine; or, in other words, in the case of contracted kidney in which albuminuria is wanting. But in addition to this application, the different physical characters pertaining to the casts are supposed to denote different morbid conditions of the kidneys. The *epithelial* casts denote simply desquamation of the epithelium of the convoluted tubes, and belong especially to acute albuminuria. The *granular* casts denote degeneration of epithelium, and belong to cases of chronic albuminuria, in which the epithelial structure is undergoing disintegration. The *oily* casts denote the transudation of oil into the tubes. The *waxy* or *hyaline* casts have an important significance according to their size. If they are small in size, they denote that they are formed in tubes in which the epithelial membrane is intact; but if large, they are formed in tubes in which the epithelium is lost. When only $\frac{3}{16}$ of an inch in diameter, they are nearly as large as the tubes themselves, and hence the latter must be denuded of their epithelial lining. If clinical experience establishes these views regarding the significance of the different varieties of casts, we may truly say that the microscope is to the diagnosis of pathological conditions of the kidneys, what the stethoscope is to the affections of the chest.

It occurs to me to remark that the importance of determining the amount of urea excreted in the urine, in cases of disease of the kidneys, is not sufficiently appreciated by the profession. The amount of urea excreted, will show whether the excretory function of the kidneys be impaired, and to what extent.

(To be Continued.)

DISLOCATION OF STERNAL END OF CLAVICLE UPWARDS.

By JNO. G. BIGHAM, M.D.

THOMAS SCOTT, a farm laborer, aged 24, on 20th December, 1860, while attempting to bridle a wild colt, in a barn, was crushed between the animal's body and the side of the building.

He could give no very definite account as to the precise direction from which the pressure was sustained. I saw him an hour after the occurrence of the accident.

He was sitting with the back of his head turned downwards and forwards towards the left shoulder. On asking

him to stand up, he still held his head in the same position, and the left shoulder drooped very considerably.

I found the sternal extremity of the left clavicle elevated directly from its fossa, as much as an inch and a half.

The clavicular portion of the sterno-cleido-mastoid muscle formed quite a bunch just over the end of the bone, and the sternal portion was rendered very tense and prominent—the extremity of the clavicle apparently resting against it.

The patient complained of extreme pain on the application of pressure upon the sternal end of the bone.

By carrying the shoulder strongly upwards and outwards, I could restore the bone to its natural position without making the direct pressure of which he complained.

The dressings used in this case were simply a pretty large axillary pad, a bandage holding the elbow down to the side, and a sling to keep the shoulder up.

The sling was arranged, by means of a sleeve, so as to give support to the lower end of the humerus and the entire forearm. The bandage was firmly applied, and the sling was made so short that the shoulder was kept above its natural level. The patient could now move his head at pleasure, without much pain. The dressing was not changed for four weeks at all, except to prevent loosening.

At the end of four weeks the bandage and pad were removed, but the forearm was kept in a sling for a fortnight longer, when union of the ligaments seemed to have been established.

The extremity of the left clavicle was slightly higher than the right; but there was no drooping of the shoulder.

On the 26th October, 1862, I examined the patient again. There was no drooping of the shoulder observable, either while standing or walking.

The degree of elevation of the extremity of the clavicle was about the same as when the dressings were left off—not to exceed a quarter of an inch.

Since the spring of 1861, this man has been constantly employed as a farm laborer, at customary wages, and finds no impediment from the injury, except in lifting anything higher than his head.

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

ADJOURNED MEETING, July 9, 1862.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DISCUSSION OF DR. BYRNE'S PAPER ON PELVIC HEMATOCELE.

(Continued from page 290.)

DR. BYRNE said: MR. PRESIDENT—Over five months have now elapsed since I had the honor to present to this Academy my paper on pelvic haematocele, and though two distinguished members favored us with their views on the subject at that time, it has since been allowed to slumber quietly, so far as this Society is concerned, until the last meeting, at which I regret to say I was not present. The long time which has thus passed without further comment, and the character of some of the remarks offered on a former occasion, make it more than probable that the subject is one which gentlemen were not yet prepared to discuss intelligently. For the very flattering, though I fear unmerited terms in which Professor Barker has referred to my paper, I cannot but feel complimented, as I am fully conscious of the value of opinions from such a source. I trust, nevertheless, that entertaining as I do the highest estimate of that gentleman's ability, I also may be permitted to "criticise where I differ from him," and that what I shall here say may be accepted in that friendly spirit which should always characterize scientific debate. I propose, therefore, with your permission, to notice in detail a few of the more prominent points in that gentleman's remarks. In looking over the report, I could not help noticing one very

remarkable inconsistency in Dr. Barker's review of my paper, and that is, that he should see fit to bestow the highest encomiums on a production in which he can find nothing whatever to commend; for, neither in the history, causes, pathology, diagnosis, nor treatment, does he agree with the author, and on some questions he differs entirely with every observer who has thoroughly investigated the subject, so far as I know.

The author is first of all reminded that the credit which he has awarded to Prof. Nelaton belongs, more properly, to Dr. Bernutz; and Dr. Barker, having thus noticed what he seems to consider a bibliographical error, proceeds to espouse the cause of the latter author in a style more forcible than complimentary to the former. This done, he next goes on to supply the historical omissions by informing you that other cases which I did not notice had been reported by Ruyisch in the eighteenth century, and by Dr. Bright, Sir B. Brodie, and M. Velpau, at a later period. It cannot be denied but that my sketch of the earlier history of bloody tumors of the pelvis was a very hurried and incomplete one; but those who may have read my paper could hardly fail to observe that a mere allusion to that part of the subject was all the writer intended to offer; because a moment's reflection will suffice to show that more space than has been devoted to the whole subject could be well and profitably occupied with a full review of the history of this disease. Therefore, a desire to curtail my remarks, as far as consistent with a general reference to the bibliography of the disease, prompted me to omit even a passing notice of many observers whose claims could hardly be disregarded with any degree of justice in a more extended and perfect treatise. Moreover, my paper was written with some knowledge of most of the earlier contributions to the pathology of intra-pelvic haemorrhages, including, of course, those most valuable and instructive papers of Dr. Bernutz, and of which no observer at all acquainted with the literature of these maladies could possibly be ignorant. I cannot, however, see wherein my error consists, in claiming for the great French clinician the merit of having been the *first* to institute a thorough and comprehensive investigation into the causes, nature, and treatment of bloody tumors of the pelvis, to which he was the *first* to give the name of "*retro-uterine haematocele*." To accomplish this end, he was obliged to summon to his aid not only the results of his own varied and almost unlimited experience, but also the many contributions of contemporary writers until then existing in a very fragmentary state. The impetus thus given to a more exact study of this class of diseases has been well exemplified by the numerous able and interesting papers which quickly followed; and no one can say that the praises bestowed by Prof. Nelaton on the labors of his pupils in this direction were unmerited.

Whether Nelaton, in his zeal, has laid himself open to the grave charge of plagiarism, is a question which I shall not stop to discuss now; but I cannot for a moment believe that he who could so well afford to be just, as well as truthful in such matters, could have been guilty of arrogating to himself, knowingly, a distinction to which he had no claim. The great bulk of the profession, particularly in France, could not have been ignorant of the existence of Bernutz's valuable memoirs, published in 1848, or of the fact that this author's researches date back as far as 1844; and, therefore, had the motives of Nelaton been such as Dr. Barker, and others previously, have attributed to him, his efforts would have been no less fruitless than dishonorable.

Regarding the supposed connexion between disordered menstruation and haematocele, I have only to repeat in substance what has been considered more fully in my paper, namely, that disordered menstruation ought to be viewed, for the most part, as one of the various symptoms following in the train of morbid phenomena, and, as a rule, having no causal connexion whatever with that pathological condition known as haematocele, because it would

seem, at least, very improbable, "that hemorrhage to such an extent as to produce even a moderately-sized retro-uterine tumor, can take place from a healthy ovary, or the vessels of a tube whose lining membrane is free from structural lesions." At the same time it is hardly necessary for me to say that I am not unmindful of the possibility, nay, the fact, that bloody extravasations within the pelvis may, and not unfrequently do, take place from mechanical obstructions, a disordered state of the circulating fluid, traumatic influences, and congestions arising from mental emotions, thereby producing imperfect ovulation; and I think I have made myself sufficiently intelligible on these points. I have, therefore, ventured to place *first on the list of predisposing causes*, "inflammation of the uterine appendages and its consequences," which I believe to be, not by any means always, but "*oftentimes the primary, and by far the most frequent among the predisposing causes of pelvic hemorrhage.*" Moreover, I am forced to conclude that ovaritis occurring independently of puerperal influences, or any appreciable primary lesion, is by no means so rare a disease as Dr. Bennet and those who accept his sweeping assertions would have us suppose. It has been stated that I have quoted, among other authors, Dr. West, in support of my opinions, on these points, which, I beg to say, is an error, though I should always place much value on statements coming from so high a source, the opinions of a very few others to the contrary notwithstanding. Because an author of whom even Dr. Bennet says, "*he looks, he examines for himself,*" and who has based his lectures on long experience derived *not from books in his library*, but from the bedside of patients in the Middlesex and St. Bartholomew's hospitals, as well as a most extensive private practice, needs no eulogium from me, and can easily afford to pass unnoticed such insinuations as I have referred to. But, in order to strengthen the position which I have taken relative to this *questio vexata*, I referred to the writings of Professor Simpson, Drs. Rigby, Ashwell, Robert Lee, Tilt, and others; and yet in the face of such authorities, and because cases of ovarian pain *apparently* resulting from ulceration of the os and cervix uteri, have been cured by topical applications to this source of the trouble, and since the contact of powerful caustic substances with the cervix —*too often, I fear, practised of late years*—has sometimes given rise to ovarian inflammation, we are again assured by Dr. Barker, that "non puerperal ovaritis is one of the most rare affections ever met with," and that "he has been for years looking for its existence in the dead-house, and doubts if he has ever seen a clear case of it."

Now with all due respect for the gentleman's acknowledged ability and acuteness of observation, I would most respectfully submit that the well known, and, I would add, generally accepted opinions of the authors whose writings I have referred to in support of my views, with the few sentences which I quoted, and which, with your permission, I will read, ought to have some weight in deciding these important questions.

On this subject Dr. Ashwell says, "Of all the organs of the human body, scarcely any seem so prone either to functional or organic disease as the ovaries; for I can with truth say that I have rarely, when examining these important organs after death, found them entirely healthy;" and Dr. Robert Lee declares that, "in many cases of disordered menstruation, chlorosis, and hysteria, which we have observed, the symptoms have been *clearly* referable to certain morbid states of the uterine appendages, and decided benefit has resulted from the application of those local remedies which were employed with a view of subduing the irritation, the congestion, or the inflammation which appeared to be present in those parts of the uterine system."

Dr. Barker has stated that the difference between Dr. Bennet and the writers referred to is, "that Dr. Bennet writes from his knowledge received at the bedside, and not from the study of authors and preconceived opinions." Now, sir, without wishing to dive too deeply into the mysteries of book-making, of which I pretend to little

or no knowledge, either practically or otherwise, I would ask whether the extracts which I have just read, not to speak of their source, bear any resemblance to the doctored, but drowsy and threadbare productions of the theoretical compiler? I think not; and so, I imagine, do most of their readers. If, therefore, I have failed to reconcile the peculiar views of Dr. Bennet touching the frequency of non-puerperal and idiopathic ovaritis with pathological facts and my own experience, I object nevertheless to being understood as endorsing the equally erroneous ideas of those who would attribute every ail to which the female organs are subject, to ovarian inflammation. Moreover, when any of the high—not *library* but practical—authorities whom I have quoted, presume to assert that non-specific inflammatory ulceration of the os and cervix uteri does not exist, I feel not only sceptical as to the statement, but amazed at such a remarkable perversion of facts.

But even Dr. Bennet must not be supposed to entertain such extreme views as my friend Dr. Barker, because he admits that ovaritis *does* occur independently of the puerperal state, and even of uterine inflammation, and goes no further than to say that it is, *in the great majority of cases*, secondary in its development.

Moreover, in his "*Review of Uterine Pathology*," he endeavors to define his position thus: "*Ovaritis exists both in acute and chronic forms, and when it is present reacts, of course, on the uterine functions, giving rise to a regular sequence of symptoms; but to attribute to sub-acute ovaritis, the cases in which tenderness, pain, and fulness of the ovarian regions are found, and to look upon the co-existing uterine lesions and symptoms as merely sympathetic conditions, is simply a pathological error, the result of pathological prepositions. It is giving to the ovaries, pathologically, the same pre-eminence in the female genital system that they really do exercise physiologically—a pre-eminence to which they have no claim.*"

Now it strikes me that this very physiological pre-eminence so flippantly disposed of, is one of the very strongest arguments in favor of a still greater modification of his original theory; because if these small, but physiologically important bodies, to which every uterine function is subservient, have little or no pathological importance, it is rather singular, that among those who not only fail to appreciate the philosophy of this style of reasoning, but denounce the doctrine as a dangerous heresy, may be numbered some of the brightest lights in our profession.

In Clay's translation of "*Kiewisch on the Diseases of the Ovaries*," page 61, that author, speaking of inflammatory exudations, the result of ovaritis, apart from the puerperal condition, says: "In post-mortem examinations they are repeatedly met with in the form of cellular membranes and bands, which are occasionally so extensive, that the ovaries, the tubes, and the broad ligaments are converted into an inextricable mass from which the ovaries can scarcely be separated." And further on at page 65, alluding to "primitive inflammation of the stroma" of these organs, he says: "Though occurring less frequently in the non-puerperal state, etc., still serious inflammations of the ovaries do exist which affect the whole of the organs, and occasion a very severe, acute metamorphosis, sometimes terminating in a short period, as happened in the case of two young persons whom we saw, in the one by an acute abscess, in the other by a sanguous disintegration (a kind of putrescence)."

Dr. Barker says: "He has examined a great many ovaries, and the amount of extravasation in no case exceeded a few drops." And again: "The ovaries are not excessively vascular organs, and do not possess vessels enough to give off from 8 oz. to 2 or 3 pints of blood." I am not surprised, sir, that Dr. Finnell, of whose opportunities and valuable contributions to pathology I need not remind this Academy, should have expressed his astonishment at such a statement; nor can I agree with Dr. Barker, whose experience in this respect, as well as the conclusions drawn therefrom, are entirely opposed to numerous well authenticated pathological facts, copious extravasations of blood

owing to excessive vascularity of that organ, and rupture of some of its dilated vessels, having been repeatedly demonstrated by many observers.

Because, therefore, the vessels of the ovary, in its normal condition, are neither large nor numerous, it surely does not follow that the tissues comprising this gland, when subjected to morbid influences, such as might follow, for instance, inflammatory congestion, should remain unaltered and intact.

In some of my more recent investigations, lately published, I have ventured to suggest that varicosity of the utero-ovarian veins in married women, and more particularly those who have been pregnant, will be found to be a frequent cause of ovaritis as well as haematocele, and that permanent dilatation of these veins, more or less, is a necessary consequence of pregnancy. If this theory be correct (and I hope by future investigations to be able to show that it is so), we have, at once, a pretty satisfactory explanation of the fact that in a large majority (perhaps four-fifths) of all the cases of haematocele recorded, the subjects have been married women.

With regard to Case I., referred to by Dr. Barker, I freely admit that, in the first instance, it was a clear example of pelvic cellulitis; but the patient had entirely recovered from this, with the exception of a not unfrequent sequel to such attacks, namely, chronic inflammation of the ovary and adjoining tissues, which, after the lapse of nine months, ended by rupture of dilated and inflamed veins within the folds of the broad ligament, and the immediate formation of a tumor. This, at least, is the only rational explanation of such a case; and I think both the symptoms and termination perfectly justify the conclusion, that it was an example of sub-peritoneal haematocele.

In this connexion I would remark, that the subsequent illness of this same patient, related in my paper as Case IV., is typical of very many others which I have met with, where the history, symptoms, and permanent benefit derived "from the application of those local remedies which were employed with a view of subduing the irritation, the congestion, or the inflammation which appeared to be present" (as Dr. Robert Lee correctly observes), prove satisfactorily to my mind, that not only in this, but many similar cases, parenchymatous ovaritis, or, perhaps, more correctly speaking, "ovarian phlebitis," is a primary and distinct disease, and wholly independent of any uterine lesion. Were it otherwise, I am at a loss to know how, or upon what pathological or therapeutical principles, to account for the satisfactory results of my treatment in such cases.

For these reasons, therefore, and to avoid misconception, I will state in a few words my position as regards the point at issue, which is, that though irritation and inflammation of the ovaries, Fallopian tubes, and surrounding tissues may take place, as sympathetic of uterine lesions, yet, that a similar condition of all or either of these parts is often a primary disease, and entirely independent of any pre-existing structural lesion whatever, so far as the uterus is concerned at least. Having thus explained my views on these questions, I would beg to remind Dr. Barker that I have not, in my paper, attempted to discuss the relative frequency of the various kinds and degrees of ovarian inflammation, nor can I see any benefit likely to arise from pursuing this part of the subject, which I consider entirely irrelevant: because, whether non-puerperal, chronic, or sub-acute ovaritis be a rare or a frequent disease, has nothing whatever to do with my position as regards the causes of haematocele. This latter I believe to be a rare disease, but it does not necessarily follow that the most frequent of all predisposing causes should be equally so, for I imagine, as I said before, that varicosity of the utero-ovarian veins will be found to be a very frequent result of pregnancy and parturition.

In relation to the symptoms which precede pelvic cellulitis, and those of haematocele, I would remark, that though, as a rule, in the one case the constitutional disturbance will be great, and in the other hardly appreciable, but the ma-

lady generally manifested by abdominal pain, more or less anaemia, great prostration, and the immediate formation of a tumor, if sub-peritoneal; still, as I have stated, "an accurate idea of the nature of these tumors will often be next to impossible, until the trocar shall have penetrated their walls."

(To be Continued.)

American Medical Times.

SATURDAY, NOVEMBER 29, 1862.

HOSPITAL FUND—ITS USES AND ABUSES.

We alluded, last week, to some of the more important instances of mismanagement in our military hospitals. They were of that class of abuses which are for the most part apparent on a casual inspection. There are others which can be determined only by inquiry, as, for example, the character of the nurses, the qualifications of the medical officers, the efficiency and honesty of the steward, the matron, and of all the subordinate employées. In this catalogue is the hospital fund, which is very generally believed to be a source of great corruption and abuse. It will not be amiss at this time to consider briefly the nature of this fund, its uses and abuses.

The hospital fund is the difference of the estimated value of the rations allowed to the hospital, and of those actually drawn. That is, Government allows to each patient a given number of rations, whether they are consumed or not. If a patient is very sick, and no ration is drawn, the value of the ration, estimated by the price of the articles in the market where the hospital is located, is credited to the hospital, and hence accrues the fund known as the hospital fund. It is evident that this fund will vary principally according to the severity of the cases in the hospital; that is, the larger the number of patients not requiring rations on account of sickness, the larger the amount credited to the hospital. Assistant-Surgeon WOODWARD, U.S.A., a recent and experienced writer on hospital management, remarks: "The hospital fund, in a properly managed hospital, should amount to from one-fourth to one-half of the total cost of the rations to which the number of patients and attendants in the hospital are entitled. Thus, in a hospital for five hundred patients, at a post where the ration is estimated at eighteen cents cost price for each full ration, the monthly savings should be, at least, six hundred and fifty dollars, and, under favorable circumstances, may swell to fourteen hundred dollars, or even more." That this is not an exaggerated statement he cites the Seminary Hospital, Georgetown, D.C., while under the efficient management of Surgeon Jos. R. SMITH, U.S.A., which, with one hundred and thirty to one hundred and fifty patients, and the average cost price of the ration eighteen cents, had a monthly saving of from three hundred and fifty to four hundred and fifty dollars. Many other instances might be given where a proportionate sum has monthly accumulated.

The manner in which this fund is to be expended is prescribed in the revised army regulations as follows: "The hospital fund, or any part of it, may be expended by the

commissary on the requisition of the medical officer, in the purchase of any article for the subsistence or comfort of the sick, not authorized to be otherwise furnished." The supply of extras to the hospital diet may thus embrace every article of the market, not included in the rations, which the surgeon may deem necessary. Eggs, chickens, milk, fruits, etc., etc., may be furnished, so as to give the most ample variety to the mess-table, and in sufficient abundance. On a recent visit to David's Island Hospitals, we found the following extra articles purchased from the hospital fund for that day, viz. fresh meat, one thousand three hundred pounds; eggs, five hundred and fifty; milk, eight hundred quarts; bread, two thousand six hundred pounds; and milk punch, two hundred and forty bottles. The number of patients was about one thousand five hundred. But the surgeon is not limited to articles of diet; he may purchase anything that adds to the comfort of the patient. He may purchase articles of clothing, combs, brooms, dishes, etc., etc., according to the wants of the hospital and of the individual patients. It will thus be seen that a well managed hospital fund is a most important feature of our military hospitals. It supplements the allowances of Government, and enables the discreet surgeon to furnish the wards with every needed article, and to supply the table and the very sick with desirable delicacies.

But this fund may be expended improperly. The surgeon may, under certain circumstances, draw the money and disburse it himself. The impression is wide-spread that in this manner large sums are appropriated by individuals. But, we believe, this is a great error. Where the surgeon receives money on account of the hospital fund, he is required to present vouchers, showing in detail its expenditure, like any disbursing officer. It is quite impossible for him to put such moneys to his own account without a system of collusion, fraud, and forgery, which few criminals even would care to encounter. We may safely conclude, therefore, that the hospital fund rarely, if ever, is appropriated directly by the medical officer.

Again, this fund may be mismanaged in the manner of its expenditure. Here is a real source of evil. If economy is not constantly exercised in the purchase of articles, the fund may be readily and rapidly misappropriated, with but little benefit to the hospital. Dishonesty, also, may be practised by collusion with the produce dealer; but we cannot believe that there is a surgeon in charge of a hospital who would stoop to so unworthy an act. The method of securing true economy in the expenditure is thus pointed out by Dr. WOODWARD: "Economy is secured by keeping the provisions and stores of the hospital under lock and key, so as to prevent all unauthorized expenditures, and comparing from time to time the daily expenditures with each other, and the number of patients, so as to become at once aware of any inadvertent extravagance; by prudence in drawing or purchasing perishable articles, such as fresh meat, etc., which should be so managed that, while there is enough for all purposes, none should be left over to spoil; by skill and economy in the management of the kitchen; by economy with the gas, lamps, or other means resorted to to light the hospital; and, finally, by taking care to make the purchases for the hospital of honest dealers, and to pay for them no more than the market price." He estimates that twenty-five to fifty per cent of the hos-

pital fund, or even more, may be lost by making the purchases of an improper person.

We are satisfied from personal observation that in no one respect is there a greater difference in the management of hospitals, than in the proper disposition of the hospital fund. Of two hospitals of equal size, and with the same average of severe cases, we may find in one the mess-table supplied only with the regular army ration; no butter, potatoes or other vegetables are ever seen by the half-starved patients, unless they purchase them with their own funds. The wards are barren of every little article of convenience, which tend so much to make them cheerful. In the other the diet is liberal, including vegetables, puddings, etc.; the walls are neatly furnished, the windows curtained, and comforts abound on every hand. We would urge every surgeon in charge of a hospital to study constantly the proper appropriation of his hospital fund.

THE WEEK.

THE effect of the rise of prices is very sensibly felt by druggists. In many instances the prices of the most common drugs have increased fifty per cent. The druggist, however, can scarcely add to his charges in the retail of drugs without receiving censure. The retail drug business must therefore suffer severely. But the retail druggist who does a large business in prescriptions has a remedy in the enormous profit on prescriptions. Physicians should be informed of this increase in the price of drugs; and as far as possible, when prescribing for the poor, select those articles least expensive, and yet capable of accomplishing the desired result.

ANOTHER case of induced abortion has come to light in this city by the death of the victim. Such an occurrence is suggestive of the thought that this is but an accidental exposure of a large and lucrative business. The public learn the fact because the operation proved fatal. How many similar operations are performed of which we know nothing, can only be surmised. There is no doubt, however, that the abortionists form a distinct craft among us, and are never in want of engagements. But they are rarely detected in their black art, and when arrested, easily escape from the grasp of justice.

THE circular of the President to the Army and Navy, requiring that no unnecessary labor be performed on the Sabbath, is designed to affect powerfully the physical as well as the moral well-being of those engaged in the public service. The rest of the Sabbath, or of one day in the seven, is one of the most imperative requirements of our nature. To the soldier and marine, who are often required to do a large amount of unnecessary duty on the Sabbath, this order will be most welcome. The majority of them can read and write, and can improve their leisure hours profitably. This circular reflects the highest possible credit upon our Chief Magistrate, who has so promptly responded to the wishes of the citizens who brought the subject to his attention.

THE regulations for the organization of Division Hospitals established by Dr. LETTERMAN, Medical Director of the Army of the Potomac, are admirably designed to give efficiency to the medical corps during battle, and to prevent

delay in dressing and operations, and consequent suffering of the wounded. Such, or a similar system, should be adopted in every branch of the army, wherever located. We earnestly commend it in detail to the attention of Medical Directors of the different Army corps.

Army Medical Intelligence.

AMBULANCE SYSTEM OF THE ARMY OF THE POTOMAC.

[Army Correspondence of the AMERICAN MEDICAL TIMES.]

In your edition of the MEDICAL TIMES for Nov. 1st, there are some editorial remarks on the Ambulance System of the Army of the Potomac. Whilst you urge the adoption of an ambulance system for the whole army, you advise that the order of General McClellan of Aug. 2d, should be adopted, in its main features. I take the liberty of inclosing a copy* of that order, and stating that at present it is in full operation in the six corps of this army, which have advanced from Berlin.

It is not generally known that this system has been but partially adopted in this army, previous to the battles of South Mountain and Antietam. At South Mountain the heaviest loss occurred after five P.M., and the fighting was continued fiercely until nine, yet a thousand wounded were carried to Middletown, a distance of three or four miles, before morning. At the battle of Antietam, the ambulances in Burnside's corps were still under the control of the Regimental Medical Officers, and the wounded in this corps, on the left, were not removed with the celerity and care that obtained on the right, where the corps of Hooker, Sumner, and Franklin were engaged, and neither horses nor men in the ambulance corps took rest or refreshment until all the wounded had been removed to the temporary hospitals.

The great virtue of Dr. Letterman's system consists in the fact that the horses, harness, wagons, etc., are under the charge of a line officer, who has no other duty to perform, and who is responsible that the ambulances are, at all times, ready to perform their duty, under the direction of the medical profession. The Medical Department still controls them completely, whilst it is relieved of the irksome care of their equipment. Several changes have been found requisite since the publication of the order, to insure its greater efficiency.

Whilst an effort should undoubtedly be made, through Congress, to improve this branch of the service, it will relieve some anxiety, and allay, to a great extent, the alarm created by such descriptions as those of Dr. Bowditch, to know, that in this army, no such horrible scenes can possibly be enacted.

NEAR WARRENTON, VA., NOV. 19.

* HEADQUARTERS, ARMY OF THE POTOMAC.

Camp near Harrison's Landing, Va., August 2, 1862.

GENERAL ORDERS, NO. 147.

The following regulations for the organization of the Ambulance Corps and the management of Ambulance Trains, are published for the information and government of all concerned. Commanders of Army Corps will see that they are carried into effect without delay.

1. The Ambulance Corps will be organized on the basis of a Captain to each Army Corps as the Commandant of the Ambulance Corps; a 1st Lieutenant for a Division; 2d Lieutenant for a Brigade; and a Sergeant for each Regiment.

2. The allowance of ambulances and transport carts will be—one transport cart, one 4-horse and two 2-horse ambulances for a Regiment; one 2-horse ambulance for each Battery of Artillery; and two 2-horse ambulances for the Headquarters of each Army Corps. Each ambulance will be provided with two stretchers.

3. The privates of the ambulance corps will consist of two men and a driver to each ambulance, and one driver to each transport cart.

4. The Captain is the Commander of all the ambulances and transport carts in the Army Corps, under the direction of the Medical Director. He will pay special attention to the condition of the ambulances, horses, harness, &c., requiring daily inspections to be made by the commanders of Division ambulances, and reports thereof to be made to him by these officers. He will make a personal inspection once a week of all the ambulances, transport carts, horses, harness, &c., whether they have been used for any other purpose than the transportation of the sick and wounded, and medical supplies; reports of which will be transmitted, through the Medi-

cal Director of the Army Corps, to the Medical Director of the Army, every Sunday morning. He will institute a drill in his Corps, instructing his men in the most easy and expeditious method of putting men in and taking them out of the ambulances, taking men from the ground and placing and carrying them on stretchers, observing that the front man steps off with the left foot, and the rear man with the right, &c. He will be especially careful that the ambulances and transport carts are at all times in order, provided with attendants, drivers, horses, &c., and the kegs daily rinsed and filled with fresh water, that he may be able to move at any moment. Previous to and in time of action, he will receive from the Medical Director of the Army Corps his orders for the distribution of the ambulances, and the points to which he will carry the wounded, using the light two-horse ambulances for bringing men from the field, and the four-horse ones for carrying those already attended to further to the rear, if the Medical Director considers it necessary. He will give his personal attention to the removal of the sick and wounded from the field and to and from the hospitals, going from point to point to ascertain what may be wanted, and to see that his subordinates (for whose conduct he will be responsible,) attend to their duties in taking care of the wounded, treating them with gentleness and care, and removing them as quickly as possible to the places pointed out; and that the ambulances reach their destination. He will make a full and detailed report after every action and march of the operations of the Ambulance Corps.

5. The 1st Lieutenant assigned to the Ambulance Corps of a Division will have complete control, under the commander of the whole Corps and the Medical Director, of all the ambulances, transport carts, ambulance horses, &c., in the Division. He will be the Acting Assistant Quartermaster for the Division Ambulance Corps, and will receipt and be responsible for the property belonging to it, and be held responsible for any deficiency in ambulances, transport carts, horses, harness, &c., pertaining to the Ambulance Corps of the Division. He will have a travelling cavalry forge, a blacksmith, and a saddler, who will be under his orders, to enable him to keep his train in order. He will receive a daily inspection report of all the ambulances, horses, &c., under his charge from the officer in charge of Brigade Ambulance Corps, will see that the subordinates attend strictly to their duties at all times, and will inspect the Corps under his charge once a week; a report of which inspection he will transmit to the commander of the Ambulance Corps.

6. The 2d Lieutenant in command of the ambulances of a Brigade will be under the immediate orders of the commander of the Ambulance Corps for the Division, and have superintendence of the Ambulance Corps for the Brigade.

7. The Sergeant in charge of the Ambulance Corps for a Regiment will conduct the drills, inspections, &c., under the orders of the commander of the Brigade Ambulance Corps, and will be particular in enforcing rigidly all orders he may receive from his superior officers. The officers and non-commissioned officers of this Corps will be mounted.

8. The detail for this Corps will be made with care by commanders of Army Corps; and no officer or man will be selected for this duty, except those known to be active and efficient; and no man will be relieved, except by orders of these Headquarters. Should any officer or man detailed for this duty be found not fitted for it, representations of the fact will be made to the Medical Director of the Army Corps to the Medical Director of this Army.

9. Two medical officers from the Reserve Corps of Surgeons of each Division, and a Hospital Steward who will be with the medicine wagon, will be detailed by the Medical Director of the Army Corps, to accompany the ambulance train when on the march, the train of each Division being kept together, and will see that the sick and wounded are properly attended to. A medicine wagon will accompany each train.

10. The officers connected with the Corps must be with the trains on a march, observing that no one rides in the ambulances without the authority of the medical officers, except in urgent cases; but men must not be allowed to suffer, and the officers will, when the medical officers cannot be found, use a sound discretion in this matter, and be especially careful that the men and drivers are in their proper places. The place for the ambulances is in the front of all wagon trains.

11. When in camp the ambulances, transport carts, and Ambulance Corps will be parked with the Brigade, under the supervision of the commander of the Corps for the Brigade. They will be used on the requisition of the regimental medical officers, transmitted to the commander of the Brigade Ambulance Corps, for transmitting the sick to various points, and procuring medical supplies, and for nothing else. The non-commissioned officer in charge will always accompany the ambulances or transport carts when on this or any other duty, and he will be held responsible that they are used for none other than their legitimate purposes. Should any officer infringe upon this order regarding the uses of ambulances, &c., he will be reported by the officer or non-commissioned officer in charge to the commander of the train, and the particulars being given.

12. The officer in charge of a train will at once remove anything not legitimate, and if there be not room for it in the baggage wagons of the Regiment, will leave it on the road. Any attempt by a superior officer to prevent him from doing his duty in this or any other instance he will promptly report to the Medical Director of the Army Corps, who will lay the matter before the Commander of that Corps. The latter will at the earliest possible moment place the officer so offending in arrest, for trial for disobedience of orders.

13. Good, serviceable horses will be used for the ambulances and transport carts, and will not be taken for any other purpose, except by orders from these Headquarters.

14. The uniform of this Corps is—for privates, a green band two inches broad around the cap, a green half chevron two inches broad on each arm above the elbow, and to be armed with revolvers. Non-commissioned officers to wear the same band around the cap as a private, chevrons two inches broad, and green, with the points towards the shoulder, on each arm, above the elbow.

15. No person will be allowed to carry from the field any wounded or sick, except this Corps.

16. The commanders of the Ambulance Corps, on being detailed, will report without delay to the Medical Director at these Headquarters for instructions. All Division, Brigade or Regimental Quartermasters having any ambulances, transport carts, ambulance horses or harness, etc., in their possession, will turn them in at once to the commander of the Division Ambulance Corps.

BY COMMAND OF MAJOR GENERAL McCLELLAN:

S. WILLIAMS, Assistant Adjutant General.

ORGANIZATION OF DIVISION HOSPITALS.

CIRCULAR.

HEADQUARTERS ARMY OF THE POTOMAC,
MED. DIRECTOR'S OFFICE, Oct. 30, 1862.

In order that the wounded may receive the most prompt and efficient attention during and after an engagement, and that the necessary operations may be performed by the most skillful and responsible surgeons at the earliest moment, the following instructions are issued for the guidance of the Medical Staff of this Army; and Medical Directors of Corps will see that they are promptly carried into effect:

Previous to an engagement there will be established in each Corps a Hospital for each Division, the position of which will be selected by the Medical Director of the Corps.

The organization of this Hospital will be as follows:

- 1st. A Surgeon in charge;
- One Assistant-Surgeon to provide food, shelter, &c.;
- One Assistant-Surgeon to keep the records, &c.
- 2d. Three Medical Officers to perform operations;
- Three Medical Officers as Assistants to each of these officers.
- 2d. Additional Medical Officers and Hospital Stewards and Nurses of the Division.

The Surgeon in charge will have general superintendence, and be responsible to the Surgeon-in-Chief of the Division for the proper administration of the Hospital.

The Surgeon-in-Chief of Division will detail one Assistant-Surgeon, who will report to, and under the immediate orders of, the Surgeon in charge, and whose duties shall be to pitch the Hospital Tents and provide straw, fuel, water, blankets, &c.; and, when houses are used, to put them in proper order for the reception of wounded. This Assistant-Surgeon will, when this shall have been accomplished, at once organize a kitchen, using for this purpose the Hospital mess chest, and the kettles, tins, &c., in the ambulances. The supplies of beef, stock and bread in the ambulances, and of arrow root, tea, &c., in the hospital wagon, enable him to prepare quickly a sufficient quantity of palatable and nourishing food. All the Cooks, and such of the Hospital Stewards and Nurses as may be necessary, will be placed under his orders for these purposes.

He will detail another Assistant-Surgeon, whose duty it shall be to keep a complete record of every case brought to the Hospital, giving the name, rank, company, and regiment, the seat and character of injury, the treatment, the operation if any be performed, and the result; which will be transmitted to the Medical Director of the Corps, and by him sent to this office.

This officer will also see to the proper interment of those who die, and that the grave be marked with a *head-board*, with the name, rank, company, and regiment, legibly inscribed thereon. He will make out two "tabular statements of wounded," which the Surgeon-in-Chief of Division will transmit within thirty-six hours after a battle; one to this office, (by a special messenger, if necessary,) and the other to the Medical Director of the Corps to which the hospital belongs.

There will be selected from the Division by the Surgeon-in-Chief, under the direction of the Medical Director of the Corps, three medical officers, who will be the operating staff of the hospital, with whom will rest the immediate responsibility of the performance of all important operations. In all doubtful cases they will consult together, and a majority shall decide upon the expediency and character of the operation. These officers will be selected from the Division without regard to rank, but *solely* on account of their known prudence, judgment, and skill. The Surgeon-in-Chief of the Division is enjoined to be specially careful in the selection of these officers, choosing only those who have distinguished themselves for surgical skill, sound judgment, and conscientious regard for the highest interest of the wounded.

There will be detailed three medical officers to act as as-

sistants to each one of these officers, who will report to him and act entirely under his direction.

It is suggested that one of these assistants be selected to administer the anesthetic. Each operating surgeon will be provided with an excellent table from the Hospital wagon, and, with the present organization for field hospitals, it is hoped that the confusion and the delay in performing the necessary operations so often existing after a battle will be avoided, and all operations hereafter be *primary*.

The remaining medical officers of the division, except one to each Regiment, will be ordered to the Hospital to act generally as assistants and dressers.

Those who follow regiments to the field will establish themselves, each one at a temporary depot, at such a distance or situation in the rear of his regiment as will insure safety to the wounded, where they will give such aid as is immediately required; and they are here reminded, that whilst no personal consideration should interfere with their duty to the wounded, the grave responsibilities resting upon them render any unnecessary exposure improper.

The Surgeon-in-Chief of the Division will exercise general supervision, under the Medical Director of the Corps, over the medical affairs in his Division. He will see that the officers are faithful in the performance of their duties in the Hospital and upon the field, and that, by the Ambulance Corps which has heretofore been so efficient, the wounded are removed from the field carefully and with dispatch. Whenever his duties permit, he will give his professional service at the Hospital, and will order to the Hospital, as soon as located, all the Hospital wagons of the brigades, the Hospital tents and furniture, and all the Hospital stewards and the nurses. He will notify the captain commanding the Ambulance Corps, or, if this be impracticable, the first lieutenant commanding the division ambulances, of the location of the Hospital.

No medical officer will leave the position to which he shall have been assigned without permission; and any officer so doing will be reported to the Medical Director of the Corps, who will report the facts to this office.

Medical Directors of Corps will apply to their Commanders on the eve of a battle for the necessary guard and men for fatigue duty. This guard will be particularly careful that no stragglers be allowed about the hospital, using the food, &c., prepared for the wounded.

No wounded will be sent away from any of these Hospitals without authority from this office.

Previous to an engagement a detail will be made by Medical Directors of Corps of the proper number of medical officers, who will, should a retreat be found necessary, remain and take care of the wounded. This detail the Medical Directors will request the Corps Commanders to announce in orders.

The skilful attention shown by medical officers of this army to the wounded upon the battle-fields of South Mountain, Crampton's Gap, and Antietam, under trying circumstances, gives the assurance that, with this organization, the Medical Staff of the Army of the Potomac can with confidence be relied upon under all emergencies to take the charge of the wounded entrusted to its care.

JONA. LETTERMAN,
Surg. and Med. Director.

CORPS OF VOLUNTEER SURGEONS.—The following named gentlemen having been examined and approved by the U.S.A. Medical Boards, have been appointed to take rank as follows, to date from November 7, 1862:—

SURGEONS.—ALEXANDER B. MOTT, New York; WILLIAM B. BREED, Pennsylvania; PLINEY A. JEWETT, Conn.; JOHN J. REESE, Pa.; JOHN O. BRONSON, Conn.; AUGUSTUS C. BOURNIVILLE, Pa.; WILLIAM S. FORBES, Pa.; T. B. GIBBONS, Pa.; FRED. S. AINSWORTH, Mass.; FRANCIS SALTER, Ohio; HOWARD CULBERTSON, Ohio; JAMES C. WHITEHILL, Illinois.

ASSISTANT-SURGEONS.—ROBERT R. TAYLOR, Pa.; E. D. KITLOE, Ill.; A. T. WOODWARD, Vt.; LEWIS D. HARLOW, Pa.; WILLIAM WATSON, Iowa; CHARLES E. SWASEY, N.H.; CALEB W. HORNER, Pa.; H. M. CRAWFORD, Ill.; LOUIS W. REED, Pa.; M. H. PICOT, Pa.; WILLIAM S. EDGAR, Ill.; EDWARD J. WHITNEY, Md.; EDWIN FREEMAN, Ohio.

ORDERS.—Surgeon D. W. HAND, U.S.A., has been placed on duty as Medical Director of Gen. PECK's Division, at Suffolk, Va., relieving Surg. A. D. GALL, 13th Indiana Vols.

Surgeons H. J. CHURCHMAN and BARTON DARRACH, U. S. Vols., have reported to Assist. Surgeon-General WOOD, at St. Louis, Mo.

Dr. H. EVERSMAN, lately in charge of Camp Dennison Hospital, has been directed to report to Surgeon HEAD, at Louisville, for duty in charge of the General Hospital, Lexington, Ky.

Surgeon WILLIAM VARIAN, U. S. Vols., has been relieved from duty at New Albany, Ind., and ordered to report to Maj. Gen. G. GRANGER, Army of Kentucky.

Surgeon BURKITT CLOAK, U. S. Vols., has been assigned to the charge of the hospitals at Camp Dennison, Ohio.

Surgeon GOLDSMITH, U. S. Vols., to duty in charge of the internal arrangements of the General Hospitals at Louisville, Ky.

Surgeon J. V. Z. BLANEY, U. S. Vols., has been ordered to turn over the property in his charge (as Medical Purveyor at Alexandria, Va.) to the Medical Purveyor at Washington, and report for duty to Gen. VIEL at Norfolk, Va.

Medical Storekeeper H. JOHNSON, U.S.A., has relieved Surgeon C. H. LAUB, U.S.A., as Medical Purveyor at Washington, D.C. Surgeon LAUB to report to the Surgeon-General for orders.

Surgeon JAMES KING, U. S. Vols., late Medical Director of the Pennsylvania Reserve Corps, has resigned his commission, having been appointed Surgeon-General of the State of Pennsylvania by Governor CURTIN.

Assist. Surgeon VAN DUYN, U. S. Vols., has been placed on duty at Jefferson Barracks, Mo.

Surgeon JOSIAH SIMPSON, U.S.A., has assumed the duties of Medical Director at Harper's Ferry.

Medical Storekeeper R. T. CREAMER, U.S.A., has been ordered to relieve Assist. Surgeon C. T. ALEXANDER, U.S.A., as Medical Purveyor at St. Louis, Mo. Assist. Surgeon ALEXANDER, on being relieved, to report to Assist. Surgeon-General WOOD, U.S.A., at St. Louis, for duty.

Assist. Surgeons R. O. CRAIG, U.S.A., and A. M. CLARK, U. S. Vols., have been ordered to report to the Medical Director, Army of the Potomac, for duty.

Surgeon J. P. G. BAXTER, U. S. Vols., on leave of absence, to report to Maj. Gen. BANKS.

Assist. Surgeon H. R. TILTON, U.S.A., now on sick leave at Barnegat, N. J., to report to Assist. Surgeon-General WOOD, at St. Louis, Mo.

Surgeon N. R. MOSELY, U. S. Vols., now Inspector of hospitals at Frederick, Md., to report to Brigadier Gen. ABERCROMBIE, U. S. Vols., as Chief Medical Officer of the troops under his command.

Surgeon A. M. HELMAN, 28th N. Y. Vols., having tendered his resignation, has been honorably discharged the service of the United States.

Assist. Surgeon R. THOMAIN, 41st N. Y. Vols., has been discharged the service, to date July 31st, 1862, for "absence without leave."

Assist. Surgeons CHARLES HEILAND, 20th N. Y. Vols., and G. F. STEVENS, of the 77th N. Y. Vols., have been dismissed the service of the United States for absence without leave.

Assist. Surgeon G. M. MCGILL, U.S.A., has returned to the Clifburne Hospital, Washington, having been on temporary duty with the Army of the Potomac since the battle of Antietam.

Assist. Surgeon S. H. HORNER, U.S.A., is engaged organizing an hospital at Camp Barry, Washington.

Assist. Surgeon B. A. CLEMENTS, U.S.A., has been re-

lieved from duty in charge of the hospitals in Georgetown, D.C., and ordered to report to the Medical Director of the Army of the Potomac.

Surgeon F. S. AINSWORTH, U. S. Vols., has been directed to report for duty in the 2d Division, General Hospitals, Alexandria, Va.

Surgeon G. W. STIPP, U. S. Vols., has relieved Assist. Surgeon CLARK, in charge of the Union Hotel Hospital, Georgetown, D.C.

Assist. Surgeon L. M. EASTMAN, U.S.A., has relieved Surgeon RUSSELL in charge of the Stewart's Mansion, Baltimore, Md.

Assist. Surgeon I. C. G. HAPPERETT, U.S.A., has been relieved from duty with the 1st U. S. Infantry, and placed in charge of General Hospital No. 2, Jackson, Tenn.

Surgeon D. H. AGNEW, U. S. Vols., has been assigned to duty as member of the Army Medical Board, at Philadelphia, for examination of Surgeons and Assist. Surgeons of Volunteers, relieving Assist. Surgeon W. C. SPENCER, U.S.A.

Surgeon BRYANT, U. S. Vols., has been directed to take charge of the Lincoln Hospital, Washington, D.C., in addition to his duties at the Clifburne Hospital.

Surgeon E. E. PHELPS, U. S. Vols., to repair to Brattleboro, Vt., for duty examining recruits.

Assist. Surgeon A. WOODHULL, U.S.A., to report for duty to the Medical Director, Baltimore.

Assist. Surgeon W. F. CORNICK, U.S.A., to report in person to the Surgeon-General for orders.

Assist. Surgeon JOHN D. LEWIS, 85th N. Y. Vols., has been dismissed the service without pay for absence without leave.

The resignations of Surgeons S. L. BIGELOW, W. W. STREW, and TIMOTHY HAINES, U. S. Vols., have been accepted, to date Nov. 6, 1862.

DR. CHAS. H. OSBORNE has been ordered to report to Surgeon J. A. LIDELL, U.S.V., in charge of the Stanton Hospital, Washington, D.C.

Assist.-Surgeon S. L. ORR, 3d Penn. Reserve Corps, to report to Surgeon J. MOSES at Harewood Hospital, Washington, D.C.

Assistant-Surgeon J. W. S. GOUELY, U. S. A., has been assigned to duty in the Office of the Surgeon-General.

Asst.-Surgeon W. M. JONES, U.S.V., has been directed to report for duty to Surgeon EDWIN BENTLEY, U.S.V., in charge 3d Division General Hospital, Alexandria, Va.

Asst.-Surgeon JAS. L. GILLESPIE, 1st Virginia Vols., has been honorably discharged the service of the United States.

The muster into service of Asst. Surgeon J. B. NEWBARK, 56th Penn. Vols., dated August 1st, 1862, has been revoked. He having tendered his resignation on account of disability, the rolls indicating that he never rendered service.

Surgeon GEO. TAYLOR, U. S. A., has been directed to assume charge of the General Hospitals at Newark, New Jersey.

Asst.-Surgeon J. W. RUGG, lately dismissed from the 5th Regiment Penn. Reserve Corps, has been restored.

Asst.-Surgeon W. L. PECK, 114th Ohio Vols., has been mustered out for promotion.

Surgeon W. S. FORBES, U.S.V., has been ordered to report for duty to Surgeon W. S. KING, U.S.A., at Philadelphia, Pa.

Surgeon C. H. LAUB, U. S. A., who since the breaking out of the rebellion has efficiently performed the duties of Medical Purveyor at Washington, D. C., has been ordered to report for duty to the Asst.-Surgeon-General, U.S.A., at St. Louis.

Surgeon T. B. REED, U.S.V., has been directed to report to Major General BANKS for duty.

Surgeon J. H. RAUCH, U. S. Vols., has been directed to report to Maj. Gen. BANKS for duty with General AUGERS' command.

Surgeon GEO. H. HUBBARD, U. S. Vols., has been assigned

to duty as Medical Director Army of the Frontier, at Springfield, Missouri.

Surgeon F. G. PORTER, Missouri State Militia, has been placed on duty as Medical Director of the troops under Brig. Gen. JAS. POTTER.

Surgeon CHAS. McMILLAN, U. S. Vols., has relieved Surgeon D. W. HARTSHORNE, U. S. Vols., as Senior Medical Officer of Gen. SHERMAN's command, Memphis, Tenn.

Assist.-Surgeon A. C. VAN DUIN, U. S. Vols., has been placed in charge of the hospital at Sedalia, Mo.

Surgeon GEO. BURR, U. S. Vols., has been dismissed the service of the United States, for drunkenness.

Surgeon T. W. FRY, U. S. Vols., has been assigned to hospital duty at Louisville, Kentucky.

Surgeon JAS. D. ROBISON, U. S. Vols., has been granted leave of absence.

Surgeon B. DARRACH, U. S. Vols., has been placed in charge of the hospitals at Camp Benton, near St. Louis, Mo., relieving Surgeon D. S. McGUIRE, of the 3d Iowa Cavalry, who has been ordered to rejoin his regiment.

Surgeon H. A. MARTIN, U. S. Vols., has been assigned to duty at Ironton, Mo.

Surgeons J. R. MCCLURE and H. J. CHURCHMAN, U. S. Vols., have been assigned to duty at Jefferson Barracks, Mo.

Hospital Steward E. A. DUNCAN, 21st Iowa Vols., has been appointed Assist.-Surgeon 38th Iowa Vols.

Surgeon SPRAGUE, of the 14th Vermont Vols., and Surgeon W. HUTCHINSON, of 22d New York Vols., have been discharged the service for incompetency.

Surgeon THORNHILL, of the 8th Wisconsin Vols., has been dismissed the service of the United States for drunkenness and neglect of duty.

Surgeon GEO. W. STIFF, U. S. Vols., has been placed in charge of the Union Hotel Hospital, at Georgetown, D.C.

Surgeon D. W. WAINWRIGHT, U. S. Vols., has been placed on duty in the office of the Medical Director, Baltimore, Md.

Orders dismissing from the service Asst.-Surgeon G. B. BALCH, 98th N. Y. Vols., have been revoked, and he will be restored to his position from August 19, 1862, provided the vacancy has not been filled.

Surgeon PETER PINEO, U. S. Vols., has been ordered to report to the Medical Director, Washington, D.C., to take charge of the Seminary Hospital, Georgetown, D.C.

Leave of absence for ten days has been granted to acting Asst.-Surgeon W. P. MORGAN, U.S.A.

Surgeon C. P. HERRINGTON, 138th Penn. Vols., on duty at Frederick, Md., has been ordered to rejoin his regiment without delay.

Surgeon W. H. CHURCH, U. S. Vols., has reported for duty at Major General BURNSIDE'S Headquarters, from leave of absence.

MISCELLANEOUS.—The Army Medical Board for examination of candidates for appointment in the Corps of Volunteer Surgeons, will in future hold their sessions in the City of Philadelphia, instead of West Philadelphia Hospital as heretofore.

The Army Medical Board at St. Louis, Mo., has been discontinued.

A Medical Board has been convened at Louisville, Ky., for the examination of candidates for appointment in the corps of Vol. Surgeons, to consist of Surgeons A. P. MEYERLT, R. L. STANFORD, and M. GOLDSMITH, U. S. Vols.

MR. FELTON, the liberal President of the Philadelphia, Wilmington, and Baltimore Railroad, has ordered the construction of cars, specially fitted up for the transportation of the sick and wounded soldiers. The Surgeon-General has also requested MR. J. W. GARRET, President of the Baltimore and Ohio Railroad, to co-operate with Mr. FELTON, in the good work.

The General Hospital at Wheeling, Va., has been discontinued.

The Medical Board now in session at Philadelphia, Pa.,

for the examination of candidates for the appointment of Assist. Surgeon in the Medical Staff of the Army, has been directed to adjourn on the 18th inst., and make a full report of its proceedings, so that the names of the approved candidates may be submitted for appointment to the War Department. Should there be, however, any candidates awaiting examination, the Board will, after making its report, immediately reassemble as a new Board, and proceed as before.

Capt. J. C. CRANE, Quartermaster at Frederick, Md., has been directed by the Quartermaster General to erect three or four buildings for hospital purposes, similar to those already in use there.

Surgeons in charge of hospitals in Washington and vicinity have been directed to send all persons afflicted with eye and ear diseases to the General Hospital on Judiciary Sq., where a ward has been set apart for such cases.

Medical Cadet DANIEL D. GILBERT, U.S.A., having passed a successful examination, has been appointed Acting Assist. Surgeon in the U. S. Navy.

Medical News.

DEATH OF DR. FRANCIS R. LYMAN.

At a meeting of the Medical Staff of Bellevue Hospital, held on the 19th inst., for the purpose of expressing their sentiments concerning the death of their late associate, DR. FRANCIS R. LYMAN, a committee was appointed to draft resolutions, and the following were presented and unanimously approved:—

Whereas, An all-wise Providence has deemed it fit to remove from his career of usefulness our friend and late associate DR. FRANCIS R. LYMAN, who died on Friday, the 14th of November, 1862, while engaged in the prosecution of his duties as Assistant-Surgeon in the Harewood Hospital, Washington city:

Therefore be it resolved, That in his death we feel that each one of us has lost a true friend, our institution one of its brightest ornaments, and the profession a disciple whose early attainments gave promise of a most brilliant career.

Resolved, That a copy of these resolutions be presented to the family of our late friend, with whom we sincerely sympathize in their affliction.

Resolved, That the resolutions be published in the AMERICAN MEDICAL TIMES, Tribune, Herald, and Times.

WM. C. PRYER, }
MUNSON COAN, } Committee.
WM. T. NEALIS, }

The Committee appointed by the French Government to inquire into the sanitary condition of French hospitals has commenced operations. The Minister of the Interior, the President, opened the meeting, assisted by M. Dumas, Rayer, and most of the French medical celebrities. The minister stated that the Emperor was surprised at the facts advanced at the discussion which took place at the Academy of Medicine, concerning the hygienic state of hospitals; and, in his solicitude for the good of the poor, he had formed this Committee, that they might inquire whether or not ameliorations could be introduced into these establishments. Above all, he asked of them that they should, besides studying the question fully and deeply, endeavor at once to recommend some means whereby the mortality might, if possible, be immediately diminished.—*Brit. Med. Jour.*

SEVERAL distinguished members of the medical profession have occupied the Chair of President of the Royal Society; but Sir Benjamin Brodie is the only surgeon who has been advanced to that dignity. Sir Hans Sloane, Sir John Pringle, and Dr. Wollaston, are the three distinguished physicians who have held the office of President. Sir Humphry Davy could not be, with any propriety, called a member of the medical profession.—*Brit. Med. Jour.*

DEATH.

GIBSON.—Died, on board the supply ship Connecticut, in the harbor of Key West, on the 6th ult., DR. WM. B. GIBSON. He was formerly House Surgeon to the Massachusetts General Hospital, and Surgeon in the Gunboat fleet in the Gulf.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 17th day of November to the 24th day of November, 1862.

Deaths.—Men, 67; women, 74; boys, 100; girls, 72; total, 313. Adults, 141; children, 172; males, 167; females, 146; colored, 4. Infants under two years of age, 98. Children born of native parents, 22; foreign, 138.

Among the causes of death we notice:—Apoplexy, 6; infantile convulsions, 18; croup, 27; diphtheria, 16; scarlet fever, 6; typhus and typhoid fevers, 8; consumption, 49; small-pox, 0; measles, 9; dropsy of head, 15; infantile marasmus, 18; cholera infantum, 2; inflammation of brain, 2; bowels, 22; of lungs, 27; bronchitis, 8; congestion of brain, 5; of lungs, 4; erysipelas, 0; diarrhoea and dysentery, 7. 169 deaths occurred from acute diseases, and 23 from violent causes. 195 were native, and 116 foreign; of whom 88 came from Ireland; 23 died in the City Charities; of whom 11 were in Bellevue Hospital, and 4 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Nov.	Barometer.		Difference of dry and wet bulb. Therm.				Wind.	Mean amount of cloud.	Humidity Saturation, 1000.
	Mean height.	Daily range.	Mean	Min.	Max.	Mean			
1862	In.	In.	•	•	•	•	N. by E.	7.7	560
16th.	30.70	.40	34	24	42	7	18	N.E.	10
17th.	30.84	.21	40	24	45	2	3	N.E.	860
18th.	30.24	.30	43	37	48	5	10	N.E.	7.5
19th.	30.00	.37	43	40	54	2	3	N.E. to S.	10
20th.	29.60	.21	54	50	60	1 1/2	2	S.E.	10
21st.	29.64	.06	48	41	55	2	8	N.E. to S.	10
22d.	29.70	.07	40	35	45	7	10	N.W.	9.7
									601

REMARKS.—16th. Flurry of snow a.m.; wind fresh; barometer very high. 17th. Light rain a.m., hard rain during the afternoon. 18th. Cloudy; wind fresh, day-time. 19th. Fog early a.m. and at sunset; rain during the day. 20th. Wind and very damp; rain during the day; barometer very low. 21st. N.E. rain storm. 22d. Very light rain early a.m., wind fresh all day. Rain for the week two inches. Sun obscured all the week.

NEW YORK ACADEMY OF MEDICINE.—*The Prognosis of Albinuria, as affecting Pregnancy, Parturition, and the Puerperal State.* By DR. B. F. BARKER. Remarks from other gentlemen may also be expected. Wednesday Evening, December 3d.

NEW YORK SANITARY ASSOCIATION.—A stated meeting of this Association will be held at 7 1/2 P.M., Thursday, December 4th, at Room No. 19, Cooper Institute.

MR. J. HYSLOP will deliver an address on "Some Neglected Considerations in regard to Ventilation," with a repetition of the illustrations by a model of MCKINNELL'S CONCENTRIC DOUBLE-CURRENT VENTILATOR.

Friends of Sanitary Reform, generally, and the public are invited to attend.

The Annual Election will take place at this meeting.

SECTION OF SURGERY AND SURGICAL PATHOLOGY.—A meeting of the above Section will be held at the house of the Chairman, DR. JAMES R. WOOD, No. 2 Irving Place, on Friday Evening, the 28th inst., at 8 o'clock.

SUBJECT FOR DISCUSSION:—Tracheotomy in Cynanche Trachealis.

SURGICAL SECTION.—At the meeting of the Surgical Section this (Friday) evening, at the house of the Chairman, DR. JAMES R. WOOD, DR. JOHN O. REILLY will read a paper entitled "Hints on Hernia."

NEW YORK COUNTY MEDICAL SOCIETY.—A stated meeting of the New York County Medical Society will be held at the College of Physicians and Surgeons, corner 23d Street and

4th Avenue, on Monday next, December 1st, at 8 P.M. DR. THOMSON will continue his paper on "Medical Observations in the Inspection of 9000 Recruits."

A Discussion on Virus Diseases will commence.

To the Medical Profession.—DR. I.

PARIOT, Honorary Professor of the University of Brussels, late Commissioner in Lunacy, and Superintendent of Ghent, has opened an Institution at Hastings, on the Hudson, for the cure of mental and nervous diseases. The house is situated in a delightful and retired spot near the Hudson with vast grounds and gardens. The system employed in this new institution (that of *free air and family life*) is based upon the moral and physical liberty of the patients who voluntarily submit to medical treatment.

Dr. P. is permitted to give for his references several gentlemen of the highest scientific authority, and Superintendents of Asylums of the United States. In town he may be consulted at Dr. Elsberg's office, 153 West 15th street, on Tuesdays and Saturdays, for mental diseases and medicolegal questions.

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has arrived from Paris with directions for use. Persons suffering from chest affections can now procure the above preparations genuine, as used by Dr. Churchill from the following agents in America.

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The original "Elixir of Calisaya

BARK.—This elegant and valuable medicinal preparation was introduced to the notice of the Faculty of this city in 1830, by J. MILHAU, the sole Inventor and Manufacturer, at which date none of those numerous firms were in existence, who, rather than give a new name to a new article, have found it more convenient within a few years to appropriate the above extensively and favorably known title; it is therefore presumable that physicians in prescribing, as for over thirty years, have reference solely to the original article made by

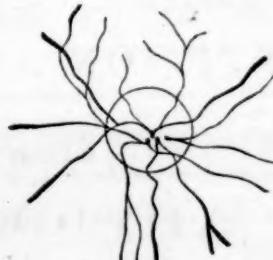
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American Journal of Ophthalmology

JULIUS HOMBERGER, M.D., EDITOR.



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